Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

LIMITS ON BENEFICIARY FINANCIAL LIABILITY (BALANCE BILLING)

APRIL 1993

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

LIMITS ON BENEFICIARY FINANCIAL LIABILITY (BALANCE BILLING)

APRIL 1993 OEI-02-92-00130

EXECUTIVE SUMMARY

PURPOSE

To report on Medicare carriers' implementation of limits on physicians' charges to beneficiaries.

BACKGROUND

Congressional interest in limiting beneficiary financial liability for physician services began with the establishment, in 1984, of the Participating Physician Program. In return for payment incentives, participating physicians must accept assignment of Medicare's approved amount as payment in full in all cases; non-participants may accept assignment on a case-by-case basis. About 19 percent of all claims are unassigned, representing 13 percent of allowed physician charges, or $5.7 billion, in 1990.

Provisions of OBRA 1989, effective January 1991, limited beneficiary responsibility for amounts physicians charged in excess of the amount allowed by Medicare. These provisions precluded physicians who did not accept assignment in 1991 from charging beneficiaries more than 125 percent of Medicare's allowed amounts for medical procedures, and more than 140 percent of allowed amounts for evaluation and management services. This new system, called "limiting charge," is also frequently referred to as "Balance Billing." In administering these restrictions, carriers monitor a sample of procedures and services for all physicians' unassigned claims for the first and second half of each year. When the cumulative amount of potential excessive charges on individual claims in the 6-month sample period exceeds $300, a notice is sent to the physician identifying all such charges. Should potential violations be confirmed, physicians are intensively monitored. If physicians continue to violate charge limits, they may be referred for civil monetary penalty or exclusion proceedings.

We collected data on monitoring activities from all carriers for the two monitoring periods in 1991. We also interviewed, either by telephone or in person, staff from a sample of twelve Medicare carriers. Case files were reviewed at six carriers we visited.

FINDINGS

Data Supplied By Carriers Indicated That The Extent Of Excessive Charges By Physicians Appeared Limited

Potential physician violations represented only four percent of all physicians submitting unassigned claims. Overcharges and beneficiaries each represented one percent or

less of the total submitted charges on unassigned claims and of the total Medicare population.

Initiatives Of Some Carriers Helped To Reduce The Financial Impact On Some Beneficiaries

Some carriers asked physicians to make refunds to beneficiaries, although this was not required by HCFA in 1991. Sixteen carriers, who accounted for 60 percent of all physicians receiving initial notices for 1991, report always requesting refunds.

All Medicare Carriers Implemented Required Monitoring Of Limits On Physicians' Charges In 1991; However, Some Did So More Intensively Than Others

Carriers' monitoring procedures for physicians who received initial notices of limiting charge violations differed in the manner of intensive monitoring. This resulted in physicians not being notified on a timely basis to correct their charging practices to fall within the charge limits, and prevented beneficiaries from receiving prompt refunds.

HCFA's Educational Efforts Focused On Physicians And Gave Very Little Attention To Beneficiaries

Carrier education on limiting charges focused almost exclusively on physicians, in an attempt to reduce charge violations at their source. A review of Explanation of Medicare Benefits (EOMB) forms for 1991 from 12 sample carriers showed that they misstated the amount that the beneficiary was responsible for paying.

RECOMMENDATIONS

Our recommendations take into account that during the course of this study HCFA: (1) had instructed carriers to request physicians to make refunds to beneficiaries in those cases where charges exceeded Medicare limits; (2) had implemented plans to revise EOMBs to provide beneficiaries with the necessary information to detect excessive charges, and (3) developed instructions on development and disposition of intensively monitored cases. Also, legislation had been introduced in the Congress requiring physicians to refund beneficiaries any amounts found to be in excess of billing limits. The legislation was not enacted, but has been reintroduced in the current session of Congress.

We support these efforts, and in addition, recommend that HCFA:

1. Contact those carriers who never notified physicians to voluntarily refund or credit beneficiaries based on 1991 violations found through monitoring, and request that they send one notice to those physicians to make refunds to, or credit the accounts of, those beneficiaries previously identified.

2. Support legislation requiring physicians to make refunds to beneficiaries for amounts collected in excess of charge limits.

COMMENTS

We received comments from the Health Care Financing Administration (HCFA) and from the Assistant Secretary for Planning and Evaluation (ASPE). Both disagree with our recommendation to now contact physicians who had not been requested to make refunds to beneficiaries for 1991 charge violations. Their reason is that there is no statutory authority requiring physicians to make such refunds.

Also, HCFA believes that it would be inappropriate to take the recommended action on a retroactive basis since at the time the violations were identified, it did not think that it had authority to instruct carriers to request physicians to make refunds. The ASPE states that "Congress enacted a different system of limits on balance billing by physicians since approximately 1984, called Maximum Allowable Charges or MAACs. The OIG's recommendation singles out only those beneficiaries who were overcharged by the new limiting charge system enacted for 1991."

Additionally, HCFA indicates that it has taken action regarding those beneficiaries who may have been charged more than the 1991 charge limits. The HCFA notes that leaflets describing the Medicare limiting charge were distributed to beneficiaries through Social Security Administration district offices, HCFA regional offices, and national beneficiary organizations. These leaflets advise beneficiaries to contact their Medicare carriers if they believe they had been overcharged for physician services in 1991. The HCFA states that it has instructed carriers to assist beneficiaries in determining whether violations occurred and in contacting physicians to request refunds.

OIG RESPONSE

We understand that current law does not require physicians to make refunds and are only recommending that HCFA issue notices to physicians requesting that they voluntarily make refunds. We believe that many physicians will do so once notified of the overcharges. We have clarified our recommendation to reflect our intent, which is to seek fair and equitable treatment for those beneficiaries serviced by those carriers which did not make such requests of physicians.

We recognize and appreciate HCFA's concern about retrospective actions. However, we believe that these actions can be taken with a minimum of effort and cost. Our study confirmed that just over half of the carriers always or sometimes requested refunds or adjustments. However, there were 26 carriers who never requested refunds or adjustments of beneficiary accounts from a total of 3,170 physicians found in violation of charge limits. That represents less than 20 percent of the total physician violators. Only these physicians need be sent a letter requesting a refund or an

adjustment of beneficiaries' accounts. This action would assure equal treatment to all overcharged beneficiaries.

We commend HCFA's initiative to remedy the unequal treatment beneficiaries received in obtaining carrier assistance in obtaining refunds for overcharges in 1991. Nevertheless, we believe that it falls short of remedying the unequal treatment beneficiaries received; the burden for identifying and correcting overcharges should not be placed on beneficiaries. Also, this remedy is limited to only those beneficiaries who received and acted upon the information in the leaflet.

As the MAAC provision on physician charges was not within the scope of this study, we are not able to comment on ASPE's observation regarding overcharges during the MAAC program.

The HCFA also provided general and technical comments on the draft report which we have incorporated in this report as appropriate. Comments from ASPE and HCFA are included in Appendix A.

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INTRODUCTION

PURPOSE

To report on Medicare carriers' implementation of limits on physicians' charges to beneficiaries.

BACKGROUND

Since the inception of Medicare, physicians have been given the option to receive payment directly from Medicare on an assigned basis or to be paid by the beneficiary on an unassigned basis. Assignment is an agreement by a physician to accept Medicare's allowed amount as payment in full. The physician accepting assignment of a Medicare claim receives 80 percent of the allowed amount, and bills the beneficiary for only the remaining 20 percent (coinsurance). When assignment is not accepted, the beneficiary is responsible for paying the physician. Medicare pays the beneficiary 80 percent of the Medicare-approved amount for the service.

Until recent years, when assignment was not accepted, a physician could charge the beneficiary more than Medicare's approved amount without any restrictions. Medicare would pay 80 percent of its allowed amount, and the beneficiary would be responsible for the full balance of the amount billed by the physician. Currently, however, when assignment is not accepted, a physician may charge no more than a specified percentage above an allowable amount established by Medicare. This limit on the amount of the physician's charge is referred to as the "limiting charge."

This inspection focused on unassigned claims in 1991 subject to Medicare's charge limits. About 19 percent of all claims are unassigned. In 1990, they represented approximately 13 percent of physicians' allowed charges, or about $5.7 billion.

Legislative History

Congressional interest in limiting beneficiary liability for physician services began with the passage of the Deficit Reduction Act of 1984. It established a Medicare Physician Participation Program designed to provide physicians with incentives to accept assignment on claims for all services rendered. Participating physicians agree to accept assignment on all claims for services furnished during the year. Physicians who do not participate may decide on a case-by-case basis whether to accept or not accept assignment.

Since 1984, several laws have been enacted which placed limits on the amounts nonparticipating physicians were allowed to charge beneficiaries. The OBRA of 1986 provided for limits on the actual charges that could be made by nonparticipating physicians, known as Maximum Allowable Actual Charge (MAAC) limits.

These provisions were replaced, effective January 1991, by a new system of limits, known as limiting charges, resulting from OBRA 1989. This new system is also frequently referred to as "Balance Billing." For 1991, physicians not accepting assignment could charge no more than 125 percent of Medicare's allowed amounts for medical procedures and, as required by OBRA 1990, 140 percent of established amounts for evaluation and management services.

Carrier Monitoring of Nonparticipating Physicians

The Medicare Carriers Manual, section 7555.1, required carriers to monitor a sample of each nonparticipating physician's charges for the first and second half of each year. (Due to delays experienced by carriers in calculating limiting charges and notifying physicians of them, the first monitoring period in 1991 was March through June; the first complete 6-month period began in July). The sample consisted of the 10 most common procedures performed in the physician's specialty. When the cumulative amount of potential excessive charges billed in the sample period exceeds $300, a notice is sent to the physician identifying all procedures and related charges. The $300 threshold may consist of a single procedure or multiple procedures with at least $1 in potential excessive charges. Physicians are asked to review the information and notify the carrier of charges they believe are not excessive or which were submitted in error. If the carrier finds that "excess charges" are adequately explained, the physician is not considered in violation. The initial notification also states that a special follow-up review of charges will be conducted to examine whether the physician's charging practices have been corrected to be within the charge limits. If charges continue to violate the limit, the matter may be referred for possible civil monetary penalty or exclusion proceedings.

The carrier follow-up review of physicians who have not satisfactorily explained excessive charges, known as "intensified monitoring," is conducted over a three- to six-month period. Should violations continue to occur, the carrier sends a second notice requesting an explanation. It indicates that charges not adequately explained will be considered as violations of OBRA limits, and that continued violations may result in referral for civil monetary penalty or exclusion proceedings.

Beneficiary Inquiries On Charges

If a carrier receives a beneficiary complaint on a potential charge limit violation and finds the complaint has merit, it sends a notification letter to the physician, even if the $300 threshold level has not been reached. Many of these complaints are made after beneficiaries are notified of physicians' charges by carriers on Explanation Of Medicare Benefits (EOMB) forms. During 1991, these EOMBs also contained information on Medicare approved charges on the amount of Medicare payment and on the beneficiary's responsibility for the balance of the physician's charge.

METHODOLOGY

At our request, all 56 carriers provided documentation on their monitoring activities and on their handling of beneficiary complaints for the first monitoring period. They also provided early information of a similar nature on the second monitoring period (just beginning at the time of our data collection). Data included: (1) the total number of physicians sent initial notices of potential charge limit violations; (2) the total number of beneficiaries involved; and (3) the total related excessive charges. While all carriers provided information, the number of responses to each of our questions varied, ranging from 39 to 56. Some carriers reported that certain information was not available; thus, the data reported in our findings do not represent the full extent of violations, excessive charges or number of beneficiaries involved.

For the purpose of verifying carriers' monitoring activities and seeing if there were any variations in implementation, we divided carriers into three groups. These groups were based upon the size of the beneficiary populations they serve: (1) more than 11 million; (2) between three and 11 million; and (3) less than 3 million. We randomly selected 12 carriers (four from each group). From them we obtained and analyzed documents regarding monitoring procedures, beneficiary and physician correspondence, HCFA instructions to carriers, and EOMB forms. Their educational activities with physician and beneficiary organizations were also reviewed.

We interviewed staff at six of the 12 sample carriers by telephone (at least one from each group) regarding their monitoring procedures and experiences. At the remaining six carriers (at least one in each group) we made site visits. The six carriers were purposively selected to provide a geographic distribution of different size carriers. At these sites, we reviewed a total of 221 physicians who had violated charge limits. We abstracted and recorded data to verify aspects of the monitoring process, including intensified monitoring. We also reviewed carriers' handling of complaints. We specifically identified excessive charges for approximately 20,000 procedures billed in the 221 violation cases, and placed them into six groups by amounts ranging from $1 to more than $100.

We also called physicians to determine whether they made refunds to or credited accounts of 36 beneficiaries identified through the case reviews as having been overcharged $100 or more. When physicians indicated that they had made refunds or credited accounts, we requested documentation to that affect. In these cases there was no indication that carriers had requested that physicians make refunds.

Lastly, we asked several beneficiary and physician advocacy organizations about their dealings with carriers and beneficiaries on limiting charges.

FINDINGS

DATA SUPPLIED BY CARRIERS INDICATED THAT THE EXTENT OF EXCESSIVE CHARGES BY PHYSICIANS APPEARED LIMITED

Identified potential violations represented only a small fraction of all charges submitted on unassigned claims; carriers' processing problems accounted for some of these identified violations

For the two 1991 monitoring periods, 49 carriers in the first monitoring period and 46 carriers in the second period reported identifying potential overcharges by nonparticipating physicians of about $11 million. This total represented far less than 1 percent of total unassigned submitted charges. It involved approximately 343,000 beneficiaries, or about 1 percent of the total Medicare population. The average excessive charge per overcharged beneficiary was approximately $32.

It should be noted that the above data is not a complete picture of the extent of excessive charges to beneficiaries. Any violations which may have occurred during the first two months of 1991 and any physicians' excessive charges which did not total $300 are not included.

For the same period, 55 carriers in the first monitoring period and 52 in the second period reported identifying 16,284 non-participating physicians whose cumulative potential overcharges on all unassigned claims were $300 or more. These physicians represented four percent of the 389,399 non-participating physicians who submitted unassigned claims to 52 carriers.

Other data reported by 54 carriers from the first monitoring period further suggest the relatively small percentage of potential physician violations. Carriers resolved 65 percent (5,919) of 9,122 potential violations they identified without needing to send second notices to physicians. Of these resolutions, nearly 40 percent (2,166) of the potential violations were caused by technical problems and not physician errors. In these cases, carriers inappropriately cited physicians with violations for a variety of reasons, although, in many instances, potential overcharges did occur. The most frequently cited reasons were: (1) carrier recoding of services which lowered limiting charges; (2) monitoring staff using different charge levels than those given to physicians; (3) not sending correct charge limits to physicians before the period being monitored; (4) miscoding multiple services as one service; and (5) using incorrect physician specialty or locality information.

A review of 221 physician violation case files at the six visited carriers revealed that the amounts of excessive charges per procedure were small. Eighty-nine percent of excessive charges were $25 or less, for the nearly 20,000 procedures rendered between

March and June 1991. The balance included five percent in the $26 to $50 range, and six percent over $50.

INITIATIVES OF SOME CARRIERS HELPED REDUCE THE FINANCIAL IMPACT ON SOME BENEFICIARIES

Some carriers on their own requested that physicians make refunds to beneficiaries

For the first and second monitoring periods, some carriers report requesting physicians to make refunds or adjustments, although they were not required by HCFA to do so. A review of files at six carriers confirmed this activity.

Regarding excessive charges identified by monitoring, 29 percent of carriers (16) say they always made such requests, 46 percent (26) report they never made such requests, and 25 percent (14) sometimes made them.

The sixteen carriers who report always requesting refunds or credits made such requests of 9,614 physicians in their service area. These physicians accounted for nearly 60 percent of all those receiving initial notices for the two 1991 monitoring periods. They rendered services to 46 percent of the beneficiaries who were potentially overcharged. Their excessive charges were approximately $4 million in 1991.

Analysis of the bills from 221 physician-cases reviewed at the six carriers we visited (two always requested physicians to make refunds and four sometimes did so) showed that for 73 percent of the 13,579 beneficiaries overcharged, their physicians were requested by carriers to refund or credit beneficiary accounts, or had voluntarily done so. However, we did identify 36 beneficiaries who were overcharged from $122 to $1,359. Carrier records did not indicate that requests for refunds or adjustments had been made. Documents we later obtained from physicians confirmed that refunds or adjustments were made for seven of the 36 beneficiaries, amounting to $2,801. However, no refunds or adjustments had been made in the remaining 29 cases, representing total potential overcharges of $14,898.

There is no legal requirement that physicians make refunds to beneficiaries, even when excessive charges are identified. The limiting charge legislation, section 1848(g) of the Social Security Act, provides only that physicians may be sanctioned for knowingly, willfully and repeatedly billing in violation of the charge limitation. However, the law is silent as to the extent of beneficiaries' responsibility for excessive charges. Thus, beneficiaries lacked official recourse to obtain refunds from physicians.

[Note: In March 1992, HCFA instructed carriers to revise their intensive monitoring follow-up notices to advise physicians to adjust their charges which exceeded the limits and to request that refunds be made to beneficiaries. It also instructed carriers to revise initial monitoring notices to reflect its position on requesting physicians to adjust charges and to make refunds where excessive charges are identified.]

ALL MEDICARE CARRIERS HAVE IMPLEMENTED REQUIRED MONITORING OF LIMITS ON PHYSICIANS' CHARGES IN 1991; HOWEVER, SOME DID SO MORE INTENSIVELY THAN OTHERS

All 56 Medicare carriers report having implemented HCFA's instructions to monitor physician charges in both of the 1991 semi-annual monitoring periods. During the first monitoring period (March - June 1991) 55 carriers report that 9,122 physicians received initial notices of charge violations. Carriers resolved and closed 85 percent of these cases as of March 1992. The open cases were still under intensive monitoring. No cases were referred for punitive action as of that time.

Our review of cases during site visits revealed that carriers' procedures differ in the manner of intensive monitoring. This resulted in physicians not being notified on a timely basis to correct their charging practices and prevented beneficiaries from receiving prompt refunds. These differences in monitoring procedures were not found to be related to carrier size. Lacking specific instructions from HCFA, carriers monitored physicians intensively anywhere from three to six months after sending a notice of the initial violation. As a result, subsequent notices to physicians of new violations vary in the degree of carrier efforts in that some notices 1) were sent every month, regardless of the size of the excessive charges; 2) were sent only after three months showing all accumulated excessive charges; or 3) were not sent if the amount is considered small.

For the first monitoring period 52 carriers reported receiving 877 beneficiary complaints of limiting charge violations. Of that number, 703, or 80 percent, were reported to have merit. Carriers had resolved 84 percent of the cases as of March 1992.

HCFA's EDUCATIONAL EFFORTS FOCUSED ON PHYSICIANS AND GAVE VERY LITTLE ATTENTION TO BENEFICIARIES

Carrier education activities on limiting charges were focused almost exclusively on physicians in an attempt to reduce limiting charge violations at their source. Sample carriers provided examples of agendas for provider seminars they conducted, bulletins they issued describing limiting charges and literature they sent to all physicians. Their efforts were considered welcome and effective, according to several physician organizations we contacted.

However, carriers did not receive instructions from HCFA to educate beneficiaries on 1991 limiting charges, according to contacts within HCFA and at 12 sample carriers. Nevertheless, these carriers reported that they were responsive to most requests from beneficiary groups to provide speakers at meetings where limiting charges were among the topics discussed.

Explanation Of Medicare Benefits (EOMB) forms in 1991 incorrectly encouraged beneficiaries to pay potential excessive charges

Our review of EOMBs for 1991 from 12 sample carriers showed that beneficiaries received misleading information on Explanation of Medicare Benefits (EOMB) forms, regarding the amount they were responsible for paying physicians. These EOMBs overstated the amount physicians could legally charge them, leading beneficiaries to believe that they were responsible for the full difference between Medicare's payments and physicians' charges, including amounts in excess of limiting charges.

In response to public concerns about this issue, HCFA instructed carriers in early 1992 to delete all reference to patients' responsibilities for physicians' charges on EOMBs. However, beneficiaries still were not alerted to excessive charges.

[Note: The HCFA added a message on the back of the EOMB, effective June 1992, which notes that doctors, generally, may not charge more than 120 percent of the Medicare approved amount. Beneficiaries are advised to contact carriers if they think their doctors have charged more than the limiting charge. This message also refers beneficiaries to the 1992 Medicare Handbook for information on limiting charges. HCFA indicated that by the end of 1992 the EOMB will display the physician's charge limit and the amount of actual charges. This will enable beneficiaries to know if the charge exceeded the Medicare limit.

Other organizations have played a role in assisting beneficiaries

Most beneficiaries have their own health insurance plans which supplement Medicare payments. These plans play a role in notifying beneficiaries about limiting charges, according to our review of documents in carrier files and discussions with both carrier staff and members of beneficiary advocacy groups. The information provided by these plans (though not always accurate) alerts beneficiaries to limiting charge violations and refers them to their physicians or carriers to resolve questions about excessive charges.

Our contacts with community-based advocacy groups indicate that they have been taking active roles in assisting beneficiaries with limiting charge problems. These groups often query carriers about limiting charge violations on behalf of beneficiaries.

RECOMMENDATIONS

Our recommendations take into account that during the course of this study HCFA: (1) has instructed carriers to request physicians to make refunds to beneficiaries in those cases where charges exceeded Medicare limits, (2) has implemented plans to revise EOMBs to provide beneficiaries with the necessary information to detect excessive charges, and (3) has developed instructions on development and disposition of intensively monitored cases. Also, legislation had been introduced in the Congress requiring physicians to refund beneficiaries any amounts found to be in excess of billing limits. The legislation was not enacted, but has been reintroduced in the current session of Congress.

We support these efforts, and in addition, recommend that HCFA:

1. **Contact those carriers who never notified physicians to voluntarily refund or credit beneficiaries based on 1991 violations found through monitoring, and request that they send one notice to those physicians to make refunds to, or credit the accounts of, those beneficiaries previously identified.**

2. **Support legislation requiring physicians to make refunds to beneficiaries for amounts collected in excess of charge limits.**

COMMENTS

We received comments from the Health Care Financing Administration (HCFA) and from the Assistant Secretary for Planning and Evaluation (ASPE). Both disagree with our recommendation to now contact physicians who had not been requested to make refunds to beneficiaries for 1991 charge violations. Their reason is that there is no statutory authority requiring physicians to make such refunds.

Also, HCFA believes that it would be inappropriate to take the recommended action on a retroactive basis since at the time the violations were identified, it did not think that it had authority to instruct carriers to request physicians to make refunds. The ASPE states that "Congress enacted a different system of limits on balance billing by physicians since approximately 1984, called Maximum Allowable Charges or MAACs. The OIG's recommendation singles out only those beneficiaries who were overcharged by the new limiting charge system enacted for 1991."

Additionally, HCFA indicates that it has taken action regarding those beneficiaries who may have been charged more than the 1991 charge limits. The HCFA notes that leaflets describing the Medicare limiting charge were distributed to beneficiaries through Social Security Administration district offices, HCFA regional offices, and

national beneficiary organizations. These leaflets advise beneficiaries to contact their Medicare carriers if they believe they had been overcharged for physician services in 1991. The HCFA states that it has instructed carriers to assist beneficiaries in determining whether violations occurred and in contacting physicians to request refunds.

OIG RESPONSE

We understand that current law does not require physicians to make refunds and are only recommending that HCFA issue notices to physicians requesting that they voluntarily make refunds. We believe that many physicians will do so once notified of the overcharges. We have clarified our recommendation to reflect our intent, which is to seek fair and equitable treatment for those beneficiaries serviced by those carriers which did not make such requests of physicians.

We recognize and appreciate HCFA's concern about retrospective actions. However, we believe that these actions can be taken with a minimum of effort and cost. Our study confirmed that just over half of the carriers always or sometimes requested refunds or adjustments. However, there were 26 carriers who never requested refunds or adjustments of beneficiary accounts from a total of 3,170 physicians found in violation of charge limits. That represents less than 20 percent of the total physician violators. Only these physicians need be sent a letter requesting a refund or an adjustment of beneficiaries' accounts. This action would assure equal treatment to all overcharged beneficiaries.

We commend HCFA's initiative to remedy the unequal treatment beneficiaries received in obtaining carrier assistance in obtaining refunds for overcharges in 1991. Nevertheless, we believe that it falls short of remedying the unequal treatment beneficiaries received; the burden for identifying and correcting overcharges should not be placed on beneficiaries. Also, this remedy is limited to only those beneficiaries who received and acted upon the information in the leaflet.

As the MAAC provision on physician charges was not within the scope of this study, we are not able to comment on ASPE's observation regarding overcharges during the MAAC program.

The HCFA also provided general and technical comments on the draft report which we have incorporated in this report as appropriate. Comments from ASPE and HCFA are included in Appendix A.

APPENDIX A

COMMENTS ON THE DRAFT REPORT

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

PDIG
DIG-AS
DIG-EI
DIG-MI
AIG-MP
OGC/IG
EXSEC
DATE SENT

Memorandum

Date FEB 5

From William Toby, Jr.
Acting Administrator

Subject Office of Inspector General (OIG) Draft Report: "Limits on Beneficiary Financial Liability (Balance Billing)" OEI-02-92-00130

To Bryan B. Mitchell
Principal Deputy Inspector General

We reviewed the subject OIG draft report concerning Medicare carriers' implementation of limits on physician charges to beneficiaries as set forth in the Omnibus Budget Reconciliation Act of 1989.

OIG found that data supplied by carriers indicated that the extent of excessive charges by physicians appeared limited: in the first two monitoring periods in 1991, potential overcharges represented less than 1 percent of total unassigned submitted charges, or about $11 million.

OIG also found that although all Medicare carriers implemented required monitoring of limits on physicians' charges in 1991, some carriers are monitoring more intensively than others. Initiatives among some carriers helped reduce the financial impact on beneficiaries. However, not all beneficiaries are as knowledgeable of this issue, nor are they able to pursue refunds from physicians who have billed above the statutory limits. OIG also noted that the Health Care Financing Administration's (HCFA) educational efforts focused on physicians while giving little attention to beneficiaries.

OIG recommends that HCFA contact those carriers that did not notify physicians to refund or credit beneficiaries based on 1991 violations found through monitoring. The carriers should send a notice to those physicians to make refunds to, or credit the accounts of, those beneficiaries who were previously identified. HCFA disagrees with this recommendation.

Our specific comments on the report's recommendation are attached for your consideration, along with general and technical comments. We appreciate OIG's acknowledgement of our efforts to improve implementation of the limiting charge provision.

Thank you for the opportunity to review and comment on this draft report. Please advise us whether you agree with our position on the report's recommendation at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG) Draft Report:
"Limits on Beneficiary Financial Liability
(Balance Billing)," OEI-02-92-00130

Recommendation

That HCFA contact those carriers who never notified physicians to refund or credit beneficiaries based on 1991 violations found through monitoring and request that they send one notice to those physicians to make refunds to, or credit the accounts of, those beneficiaries who were previously identified.

HCFA Response

We disagree. As OIG noted, HCFA does not have statutory authority to require that physicians refund excess charges to beneficiaries. To take the recommended action on a retroactive basis would be inappropriate since at the time these violations were identified, we did not believe we had the authority to instruct carriers to request, much less require, refunds of excessive charges.

HCFA has taken administrative action that addresses OIG's concern about limiting charge violations that may have occurred in 1991. HCFA developed a leaflet that specifically explains the Medicare limiting charge requirements and invites beneficiaries to contact their carriers if they believe they have been overcharged for services furnished in 1991. The leaflets were distributed to beneficiaries through Social Security Administration district offices, HCFA regional offices, and 63 national beneficiary organizations. Medicare carriers have been instructed to assist beneficiaries in determining whether violations occurred in the past and in contacting physicians to request refunds.

In view of the current absence of statutory language requiring refunds, we believe that addressing possible 1991 violations in this way is more appropriate, effective, and administratively feasible than the approach outlined in OIG's draft recommendation.

Since the legislation referenced on page eight of the draft report was not enacted, OIG may want to substitute a recommendation relating to the introduction or support of legislation requiring physicians to make refunds to beneficiaries for amounts collected in excess of the limiting charge amount.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

OCT 6 1992

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PDIG	
DIG-AS	✓
DIG-EI	
DIG-OI	
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EXSEC	✓
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RECEIVED
OFFICE OF INSPECTOR GENERAL
92 OCT -8 AM 2:07

TO: Bryan B. Mitchell
Acting Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Report: "Limits on Beneficiary Financial Liability (Balance Billing)" – *NONCONCURRENCE*

This inspection report was prepared in response to concerns raised by the Physician Payment Review Commission and beneficiary advocacy groups about the adequacy of HCFA's implementation of the "limiting charge" provision of the Omnibus Budget Reconciliation Act of 1989. This provision precludes physicians who do not accept Medicare assignment from charging beneficiaries more than 125 percent of Medicare's allowed amounts for medical procedures, and more than 140 percent of allowed amounts for evaluation and management services in FY 1991. This new system is frequently referred to as "balance billing limits."

I do not object to the body of this report but disagree with OIG's recommendation to HCFA to:

> Contact those carriers who never notified physicians to refund or credit beneficiaries based on 1991 violations found through monitoring and request that they send one notice to those physicians to make refunds to, or credit the accounts of, those beneficiaries who were previously identified.

There are several reasons for my opposition. First, there is no clear legal authority to require physicians to refund to beneficiaries any amounts charged in excess of limiting charges. While it is GC/HCFA's position that beneficiaries are not liable for amounts in excess of the limiting charge, and that it is therefore appropriate to request that physicians refund the excess to patients who have overpaid, there is no legal requirement that physicians make such refunds. Currently the Social Security Act provides only that physicians may be

sanctioned for knowingly, willfully, and repeatedly billing in violation of the charge limitation. Legislation is pending that would require physicians to make such refunds, but until its enactment, HCFA and the carriers would have trouble compelling physicians to comply.

Second, Congress enacted a different system of limits on balance billing by physicians since approximately 1984 called Maximum Allowable Actual Charges or MAACs. The OIG's recommendation singles out only those beneficiaries who were overcharged by the new limiting charge system enacted for 1991. The recommendation is therefore weak, not just because it is retroactive, but also because it favors one group of beneficiaries, namely, those who were overcharged in 1991, over all those beneficiaries charged more than the MAAC in the years 1984 through 1990.

For both of these reasons, implementing the OIG's recommendation would not justify the cost. Because there are no clear legal sanctions to force recalcitrant physicians to make the refunds, and because the recommendation treats a specific group of overcharged beneficiaries differently from many others in a similar position, I disagree with the recommendation.

I understand that HCFA will have comments on the report and may raise these same concerns.

Thank you for the opportunity to comment on this report.

Martin H. Gerry